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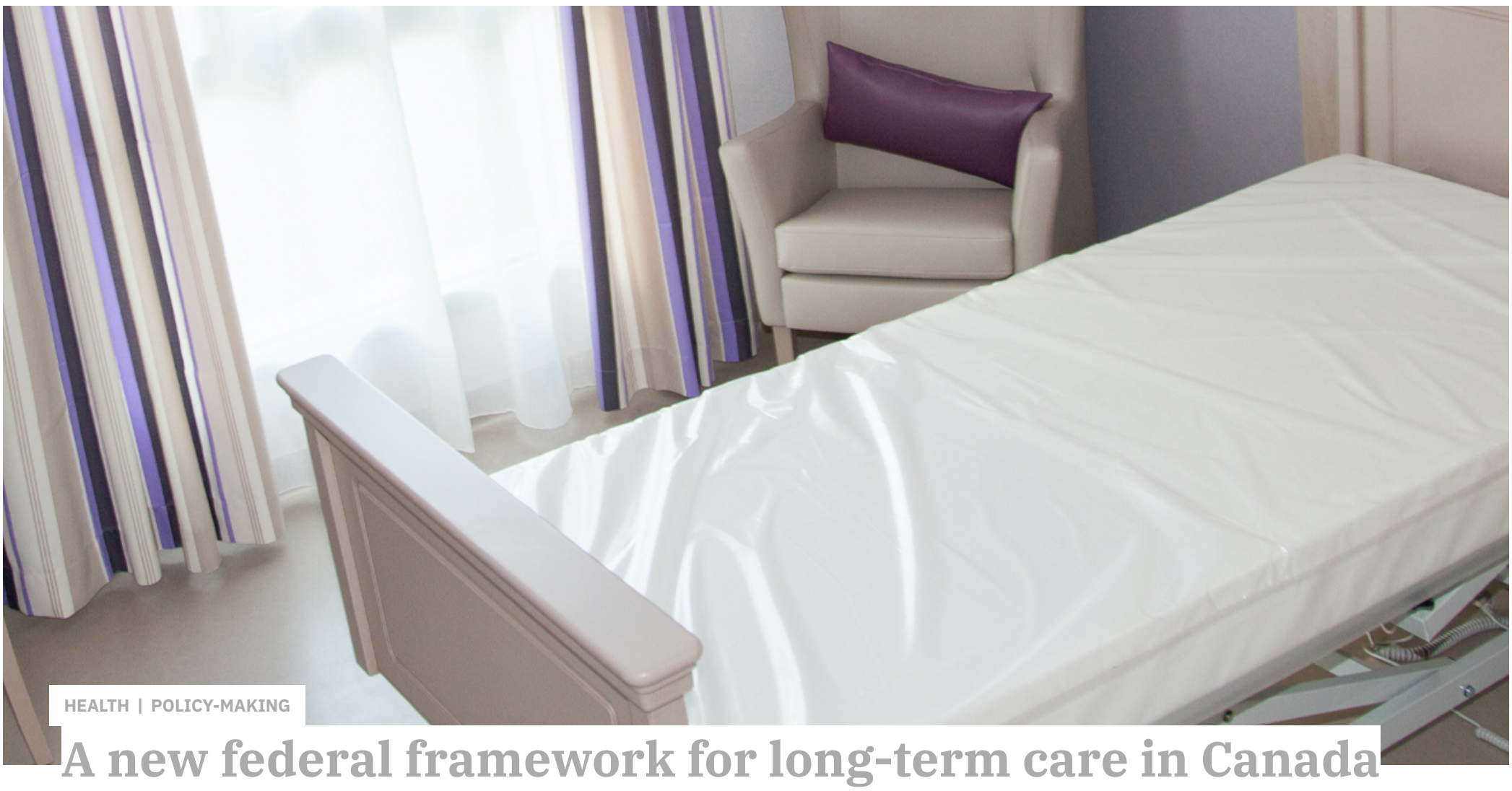

HEALTH | POLICY-MAKING

A new federal framework for long-term care in Canada

A “joint-decision” model of federalism would have federal and provincial governments act in concert to address festering problems in long-term care.

by Carolyn Hughes Tuohy

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In the grim international league tables of total deaths from COVID-19, Canada occupies a middling position. But when we turn to the share of deaths accounted for by residents of long-term care homes, Canada has the unwanted position of leading the list (figure 1). More than 80 percent of Canadian COVID-19 deaths have been in long-term care facilities, a higher proportion than in any other country. This is a dire and lamentable history. But its jarring effect on public consciousness may prove to be what it takes for Canadian governments, and Canadian society as a whole, to address long-neglected issues of quality and access in long-term care (LTC).

We need to define this problem in context. Fewer than 2 percent of all LTC residents in Canada have died of COVID-19, and those deaths have disproportionately occurred in a relatively small number of facilities. (For example, 9 percent of Ontario’s LTC homes accounted for 86 percent of all deaths of LTC residents.) But the fact that the deaths are concentrated in a problematic segment makes it no less urgent.

As the public policy agenda turns to addressing these festering problems, there have been calls for the federal government to play a stronger role: in developing national standards, providing new funding or both. However, LTC is an area of provincial jurisdiction, and the various provinces have adopted a wide range of policies and organizational models. If nationwide standards of quality and access are to have any teeth, and if new funding is to buy expansion and improvement, the federal and provincial governments will need to act in concert. We need to find ways of working within the institutions of Canadian federalism to exploit the strengths and minimize the weaknesses of Canada’s distinctive federal model.

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care in accordance with conditions and lifestyle preferences in local catchment areas. The federal government has a nationwide pool across which to collectivize and spread the financial risk of LTC. In addition, multiple jurisdictions provide venues for experimentation with policy options, while intergovernmental connections allow for diffusion of best practices and pressures for cross-provincial equity. So far, Canada has not realized these advantages, and has succumbed instead to the inherent danger that federalism leads to a patchwork result, without cross-provincial learning about what works and what doesn't.

Most recent calls for an increased federal presence in long-term care would essentially extend the model of federalism that dominates much of health care in Canada: federal financial transfers to provinces with conditions attached. Indeed, LTC is already included in the Canada Health Act as a basis for federal transfers, albeit with fewer and lighter conditions than apply to physician and hospital services. (Provinces have only to provide information on their LTC programs and give public recognition of federal government support.) On occasion the federal government has sought to direct funding to areas outside the physician-hospital sector, such as home care and mental health, through separate federal-provincial "accords" or bilateral agreements.

However, the fiscal transfer model — dubbed "shared-cost federalism" by Queen's University political scientist Keith Banting — leaves the federal government "pushing on the strings" of conditional funding, with little effective leverage. The similarity of physician and hospital services insurance programs is not attributable to the federal fiscal muscle: only "extra-billing" by physicians has ever been sanctioned by the withholding of federal funds from offending provinces, and then only in amounts that are negligible in the context of the size of the transfer. Cross-provincial similarity is better explained by an aspect of the Canadian federation beyond governments themselves: a powerful medical profession organized at the provincial level, with common interests and with strong nationwide networks, which has no counterpart in LTC. Beyond the physician-hospital sector, federal-provincial "accords" and agreements have had limited effect. Flowing federal transfers into general provincial revenues, as these transfers do, would require LTC to compete with acute care in the budget process — a competition that has historically disadvantaged LTC.

We need to turn instead to another model of federalism — Banting's "joint-decision" model — by exploiting areas of concurrent jurisdiction that give both orders of government a robust role while requiring cooperation. In a forthcoming Insight paper for the Institute for Research on Public Policy, I consider two such areas: old age security (to provide both funding and harmonization of benefits) and immigration (to level up standards for the qualifications and working conditions of caregivers). In this short piece I shall focus on only the first of these areas.

Michel Grignon and Samantha Pollex recently argued that Canada should adopt a program of long-term care insurance (LTCI). I fully endorse this proposal, which, among its other advantages, is much better suited to realizing the advantages of Canadian federalism than is the fiscal transfer model. LTCI could be added to the Canada Pension Plan/Quebec Pension Plan as a supplementary benefit, governed and administered through the established CPP/QPP infrastructure. Like the CPP/QPP it would be funded through employer and employee contributions but held in a segregated fund. For those with a limited work history, an LTC benefit would be added to Old Age Security/Guaranteed Income Supplement payments. Benefits would be paid in the form of a cash transfer to the beneficiary (comparable to other flat-rate benefits such as payments for dependent children of recipients of survivor and disability benefits), using a tiered schedule of flat-rate payments according to the beneficiary's level of assessed need for care. Payment would be triggered once the beneficiary's need has been assessed through existing provincial mechanisms but according to agreed-upon national standards, and they could be used only for care from those approved under the plan as "qualifying" providers of institutional or home care. Establishing national standards for "qualifying" providers would provide a mechanism for cross-provincial harmonization and learning.

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governments. On the CPP/QPP model, it could be designed to be self-sustaining so that contribution rates could be adjusted according to actuarial projections unless federal and provincial governments choose and agree to intervene. It would thus establish a dedicated LTC funding stream in perpetuity that would be sensitive to demographic change and would not have to be continually renegotiated through the budget process and/or in the federal-provincial arena, as is the case for the Canada Health Transfer and related transfers. Countries such as Germany, the Netherlands and Japan have demonstrated success with public LTCI and offer models from which Canada can learn.

Numerous design details would need to be considered in the process of policy development. The principal challenge would be how to integrate LTCI with existing provincial programs of LTC in institutional and home settings. The current and projected need for substantially increased operating expenditure — estimated to require an additional $14 billion (in 2017 dollars) for new nursing home beds by 2035 — means that LTCI should be seen as adding to, not replacing, current provincial funding for LTC. However, the LTCI benefit could free up provincial funding currently allocated to subsidies to individuals, which could be directed toward increasing the number of places in institutional and home care programs. The impact of such incremental funding could be substantial: in Germany, a 0.5 percentage point increase in the LTCI contribution rate allowed for more than doubling the number of support staff in LTC homes from 2013 to 2017.

Canadian federalism can work in long-term care. We just need to be smart in using the tools it offers.

This article is part of the Facing up to Canada's long-term care policy crisis special feature.

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